

the circulation. Pyæmia subsequently develops. In addition to these we see gonorrhœal cases and puerperal tetanus, caused by the tetanus bacillus.

It is urged that these cases be reported to the authorities, just as scarlatina, diphtheria, and other contagious and infectious maladies are reported. It is hoped by this means that puerperal fever may be reduced in frequency, and that important statistics may be gathered which will throw new light upon this disorder.

Cœliohysterectomy for Contracted Pelvis.—In the *Scottish Medical and Surgical Journal*, September, 1900, BREWIS reports the case of a patient whom he saw in labor and in whose case craniotomy was performed. The patient recovered and subsequently became pregnant again. She had a symmetrically contracted pelvis of a high degree of contraction. She assented to any operation which would save her child and would spare her the possibility of further pregnancy. Accordingly, the child was extracted by Cæsarean operation. The ovarian arteries and vessels accompanying the round ligaments were tied and the broad ligaments divided. A peritoneal flap in the lower part of the uterus was pushed down along with the bladder. The uterine arteries were then secured and the body of the uterus was removed. The stump was sutured and covered by peritoneal flaps. The patient made an excellent recovery.

Cephalotripsy for the Aftercoming Head.—At the last meeting of the British Medical Association, TARGETT described the case of a patient, aged twenty-nine years, a rachitic dwarf. The pelvis was highly contracted, the true conjugate not exceeding two and three-quarter inches. The patient declined to submit to Cæsarean section, and labor was induced. There was entire lack of action on the part of the uterus. Dilatation was performed by elastic bags, version was done, and the breech brought down into the cervix, but without exciting uterine contractions. It became necessary to deliver, when it was found that the head could not pass through the brim. The occiput pointed to the right, and the face was to the left, and flexion was well performed by traction upon the jaw, yet delivery could not be accomplished. Accordingly, the head was perforated in the suboccipital region. The lower blade of the cephalotribe was then applied over the face, but it was impossible to pass the upper blade over the occiput. Accordingly, the upper blade was passed through the suboccipital perforation and the head crushed. The occiput was rotated in front and the head delivered without further difficulty. The patient made a good recovery.

He also described a case in which perforation and cephalotripsy had been performed, but the head was high in the pelvic cavity and the trunk would not enter the brim. Internal version was performed and the child extracted with difficulty.

In the discussion others related cases in which version after craniotomy was most successful.—*British Medical Journal*, 1900, No 2072.

The Second Stage in the Formation of the Human Placenta.—In the *British Medical Journal*, 1900, No. 2072, TUSSENBOECK gives the following results from her investigations in this subject. The macroscopical form of

the placenta is completed about the sixth month of pregnancy. At that period the decidua reflexa has almost totally disappeared. The reduction of the decidua reflexa is the effect of mechanical pressure. The villi of the chorion, which disappear, are removed chiefly by the obliteration of the intervillous spaces between the chorion and reflexa.

The Prevention and Treatment of Post-partum Hemorrhage.—This subject was discussed at the recent meeting of the British Medical Association, the basis for the discussion being a paper contributed by BYERS, of Belfast (*British Medical Journal*, 1900, No. 2072). It is stated that the average amount of blood lost in childbirth is about one pound. Clinically, however, no fixed amount can be taken as constituting hemorrhage, as each patient differs in this respect from others. The obstetrician must expect that post-partum hemorrhage may occur where there is a history of hemorrhage at previous confinements, where pregnancies follow each other rapidly, where patients take little exercise, eat freely and use stimulants, in elderly primiparæ, and where metritis exists during pregnancy. Overdistention of the uterus or the presence of a tumor also favors hemorrhage. Albuminuria, extreme mental depression, and disturbances of the vascular system predispose to it. During labor, pains which are strong and quick, but cease suddenly, with long intervals between the pains, should arouse suspicion of uterine exhaustion; rapid, jerking pulse, with low tension, is also present in many of these cases.

In prophylaxis, attention is called to the importance of managing properly the third stage of labor. The left hand of the obstetrician must follow down the uterus, not using massage or stimulating it in normal cases, but controlling it. The cord is tied by two ligatures—one near the child and the other close to the vulva of the mother. When the placenta has been separated several inches of the cord are expelled; this can be determined by the altered position of the ligature upon the cord. The separation of the placenta is also recognized by a swelling detected above the pubes, due to the bulging of the lower uterine segment, and sometimes taken for a distended bladder. The uterus rises up suddenly and becomes more movable than formerly.

In addition to the proper delivery of the placenta and the removal of all portions, it is most important in avoiding post-partum hemorrhage not to deliver in the absence of pains. This is almost sure to be followed by severe hemorrhage. Byers counsels the use of strychnine and ergot before and during labor in suspected cases, with hydrochloric acid in plethoric patients and iron in those who are anæmic.

In the actual treatment of hemorrhage he would use uterine massage, hot intra-uterine douching with normal salt solution, the introduction of the hand and the removal of adherent portions of placenta or membrane, packing the uterus with antiseptic gauze, and dragging down the uterus, after gauze packing, by stout tenaculum forceps passed through the lips of the cervix. Should hemorrhage occur from lacerations they must be closed by suture. In after-treatment the injection of normal salt solution and stimuli, with abundant nourishment, is indicated.

In discussion, BOXALL thought the loss of blood in labor to be not less